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Laparotomy was required for 10 episodes (20%). 27 episodes (55%) required minor operation such as removal of F.B or closure of skin laceration. Of the two patients admitted with insertion of foreign body per rectum, one required laparotomy to retrieve a glass.

INTRACORPOREAL ANASTOMOSIS IN RIGHT HEMICOLECTOMY – A SAFE PROCEDURE

M. Gowda, K. Maude, J.P. Griffith. Bradford Royal Infirmary

Introduction: Laparoscopic extracorporeal anastomosis (ECA) in right hemicolectomy has been routinely performed in our department since February 2003. Intracorporeal anastomosis (ICA) was introduced in April 2007 allowing specimen retrieval via a smaller left iliac fossa incision. We compare our experience of ICA with ECA.
Method: Prospective audit of 73 consecutive patients undergoing right hemicolectomy was performed. Data collected were patient demographics, BMI, duration of operation, type of anastomosis, previous surgery, conversion rate, histology, operative blood loss, length of stay and post operative complications. Statistical analysis was performed using mann-whitney test.
Results: 48 ECA and 25 ICA were performed. There was no significant difference in sex distribution (ECA; male 24, female 24 vs. ICA; male 9, female 16 ($p = 0.254$)) and median age at operation (ECA; 72.5 years vs. ICA; 70 years ($p = 0.898$)). ECA took longer than ICA; median 163.5 vs. 142 minutes respectively ($p = 0.041$). Length of stay was significantly shorter in those undergoing ICA (ICA; 4 days vs. ECA; 6 days ($p<0.001$)). There was one anastomotic leak in the ECA group.
Discussion: The ICA offers a comparable, safe alternative to ECA in laparoscopic right hemicolectomy. Reduced hospital stay is an added advantage possibly related to a smaller lower abdominal incision.

LUMBAR CHEMICAL SYMPATHECTOMY IN PERIPHERAL VASCULAR DISEASE: DOES IT STILL HAVE A ROLE? – A NATIONAL SURVEY

P.N. Nesargikar, M.K. Ajit, J. Wilmot, B.J. Nichols, P.S. Eyers, J.F. Chester. Taunton and Somerset NHS Trust

Introduction: Lumbar chemical sympathectomy(LCS)is used principally in inoperable peripheral vascular disease (PVD) to alleviate symptoms of rest pain. No guidelines currently exist for its use in PVD. The aim of this study was to evaluate the role of LCS with regards to indications and outcomes in the UK and Irish vascular practice.
Methods: Specifically designed questionnaires were sent to Vascular Surgical Society members.Questions related to their current use of LCS including indications, outcome parameters, use in diabetics and complications encountered.
Results: 490 questionnaires were sent out and 242 responses(49%) were received. Responses covered 84 vascular departments. 75% of respondents felt that LCS still had a role in current practice. 78% performed less than 10 procedures per year. Inoperable PVD with rest pain was the main indication in over 80% of responses, with 27% using it for treatment of ulcers. Only 21% used LCS in diabetics. Symptomatic clinical improvement was used to assess outcome following LCS in 96% of responses.
Conclusion: Our study shows that majority continue to use it, though evidence for its efficacy has been equivocal. Clear guidelines regarding patient selection and indication can redefine the role of LCS in peripheral vascular disease.

PATTERNS OF RECURRENCE FOLLOWING GASTRO-OESOPHAGECTOMY – IS THERE A ROLE FOR ADJUVANT RADIOTHERAPY?

N.C. Carter, S. Mercer, N. Davies, M. Bayne, T. Geldart. Royal Bournemouth Hospital

Aims: Circumferential resection margin (CRM) involvement is an independent prognostic marker for recurrence following surgery, and it is speculated that adjuvant radiotherapy following R1 resection might be of benefit.
Methods: All patients undergoing oesophagectomy during a 6 year period at one centre were studied. Data regarding pathology and survival were collected and analysed. Survival was calculated with Kaplan-Meier Survival Curves and Log Rank analysis.
Results: 127 Patients had a minimum of 12 months follow up (median 41). There were 80 (63%) R0 resections and 47(37%) R1 resections. 9 patients were excluded from analysis (8 hospital deaths and 1 incomplete data). R0 median survival was 6.11 years, R1 19 months ($p < 0.0001$). 32 (71%) of the R1 patients recurred during the study period, locoregional in 5 (16%) and systemic in 27 (84%). 15 (21%) of the R0 resections recurred, 5 (33%) locoregional and 10 (67%) systemic. Median survival for all those who recurred was 19 months.
Conclusion: 84% of the R1 recurrences were systemic. This propensity for distant haematogenous recurrence suggests that adjuvant radiotherapy to the tumour bed would add little to survival, even in those with an involved resection margin.

THE EFFECT OF BODY MASS INDEX (BMI) ON OUTCOMES FOLLOWING OESOPHAGECTOMY

K. Thomson, G. Khera, N. Howes, R. Page, C. Magee. Liverpool Heart and Chest Hospital

Introduction: Morbid obesity is a significant risk factor for oesophageal cancer and may contribute to poorer outcomes following oesophagectomy due to surgical and post-operative difficulties. We investigated the effect of BMI on outcomes following oesophagectomy.
Methods: A prospective database of all oesophagectomies performed at a collaborative upper GI/thoracic cancer centre from 2002 was analysed. Endpoints were 5-year survival, length of stay and in-hospital mortality. Statistical analysis was performed using the Kaplan-Meier, Chi squared and Mann-Whitney U(MWU) tests.
Results: 326 cases were identified. There was no difference in in-hospital mortality for the morbidly obese (7%v 7% $p = 0.97$ Chi Squared) or length of stay (median 13 days v 13 days, $p = 0.87$ MWU) in the morbidly obese. Similar findings were found with the obese (BMI>30) and overweight (BMI>25). However, in-hospital mortality and length of stay were significantly higher for those with a BMI<20. Morbid obesity was not associated with poorer survival following oesophagectomy ($p = 0.963$), however patients with BMI<20 did have poorer survival ($p = 0.016$). Interestingly there was a trend towards longer survival in patients with BMI>25 but this did not reach significance ($p = 0.07$).
Conclusions: Patients with morbid obesity who undergo oesophagectomy can expect similar results to their lighter counterparts.

SHOULD INFRAINGUINAL BYPASS SURGERY BE PERFORMED BY UNSUPERVISED TRAINEES?

K. Akbari, N. Pal. Queen Alexandra Hospital, Portsmouth NHS Trust